

**MEDICAID FUNDING FOR NURSING HOME SERVICES:
A HISTORICAL PERSPECTIVE**

by

**John S. Walker
Chief Analyst**

**Steve Angelotti
Fiscal Analyst**

**Dana Patterson
Fiscal Analyst**

June 2000

THE SENATE FISCAL AGENCY

The Senate Fiscal Agency is governed by a board of five members, including the majority and minority leaders of the Senate, the Chairperson of the Appropriations Committee of the Senate, and two other members of the Appropriations Committee of the Senate appointed by the Chairperson of the Appropriations Committee with the concurrence of the Majority Leader of the Senate, one from the minority party.

The purpose of the Agency, as defined by statute, is to be of service to the Senate Appropriations Committee and other members of the Senate. In accordance with this charge the Agency strives to achieve the following objectives:

1. To provide technical, analytical, and preparatory support for all appropriations bills.
2. To provide written analyses of all Senate bills, House bills and Administrative Rules considered by the Senate.
3. To review and evaluate proposed and existing State programs and services.
4. To provide economic and revenue analysis and forecasting.
5. To review and evaluate the impact of Federal budget decisions on the State.
6. To review and evaluate State issuance of long-term and short-term debt.
7. To review and evaluate the State's compliance with constitutional and statutory fiscal requirements.
8. To prepare special reports on fiscal issues as they arise and at the request of members of the Senate.

The Agency is located on the 8th floor of the Victor Office Center. The Agency is an equal opportunity employer and is subject to the Americans with Disabilities Act.



Gary S. Olson, Director
Senate Fiscal Agency
P.O. Box 30036
Lansing, Michigan 48909-7536
Telephone (517) 373-2767
TDD (517) 373-0543
Internet Home Page <http://www.senate.state.mi.us/sfa/>

ACKNOWLEDGMENTS

This is the fourth in a series of studies requested by Senator Joel Gougeon, Chairman of the Senate Appropriations Subcommittee on Community Health, on the Michigan Medicaid Program. A sincere thanks to Dennis Madalinski at the Medical Services Administration Unit of the Department of Community Health for his assistance in obtaining much of the raw data needed for this analysis and to our secretary, Pam Yeomans.

TABLE OF CONTENTS

INTRODUCTION	1
MEDICAID NURSING HOME FUNDING SINCE FY 1989-90	2
WAGE PASS-THROUGHS: A CLOSER LOOK	4
FACILITY OCCUPANCY	6
RATE INCREASES FOR LONG TERM CARE VERSUS THOSE FOR OTHER MEDICAID PROVIDERS	7
CONCLUSIONS	7
ENDNOTE	9

INTRODUCTION

Much of the attention in this year's Department of Community Health (DCH) budget deliberations has been devoted to Medicaid managed care and payment rates for doctors and hospitals. Those issues, however, are only part of the Medicaid budget picture. Somewhat overlooked in the discussions is the second largest line item in the entire DCH budget, with Fiscal Year (FY) 1999-2000 appropriations of almost \$1.1 billion, the Long Term Care Services line item.

Expenditures from the Long Term Care Services line item cover long term care costs for Medicaid eligible individuals, both in Class I facilities (which are the typical nursing homes) as well as Class III facilities, which are County Medical Care Facilities (MCFs) and Hospital Long Term Care Units (LTCUs). The line item also funds the Home and Community Based Waiver program, but that program is not the focus of this paper. The primary issues explored in this paper involve the Class I facilities, although the MCFs and LTCUs are also relevant to this discussion.

The population receiving long term care services paid by the Medicaid program differs substantially from the overall Medicaid population. The Medicaid long term care population mostly consists of poor elderly people who are living in nursing homes. Most of these people were not eligible for Medicaid prior to entering the nursing home; they became eligible because they "spent down" to a certain protected income level. In other words, they paid their own money for nursing home services until their net remaining income and assets were reduced to the protected level, when they became eligible for Medicaid coverage. Because most of this population is not categorically eligible for Medicaid (rather they are considered "medically needy"), the nursing home population differs from poor children, recipients of cash welfare, and disabled people who all categorically qualify for Medicaid.

The primary reason for Medicaid covering these services is the gaps in services covered by the Federal Medicare program. While Medicare covers physician and hospital services as well as short-term skilled nursing care costs, it does not cover extended stays in long term care facilities. Thus Medicaid is, for many institutionalized elderly, the de facto "Medigap" insurance coverage for long term care services.

Due to this pre-eminent position for Medicaid in long term care, it is no surprise that Medicaid is the proverbial "900-pound gorilla" among the payers for nursing home services. In Michigan and across the nation, two-thirds of all long term care is paid by the Medicaid program. Roughly 10% of the nursing home population at any given time is covered by Medicare (for shorter term stays that are covered by the Medicare program) and costs of the other nursing home residents are covered through private pay or private insurance.

The situation with long term care is, in fact, atypical for the Medicaid program. While Medicaid pays for 67% of all nursing home days, the program pays for only 14% of all hospital bed days and 25% of all managed care in the State. Unlike the situation for hospitals, where Medicaid is only a marginal player, Medicaid is the prime player in long term care in Michigan.

In this paper the Senate Fiscal Agency (SFA) will examine Medicaid funding for long term care services. Among the issues to be explored are changes in per diem funding over the last decade, the effects of legislatively-mandated wage pass-throughs, facility occupancy, and how long term care has fared compared with other Medicaid providers in terms of rate increases provided by the State.

MEDICAID NURSING HOME FUNDING SINCE FY 1989-90

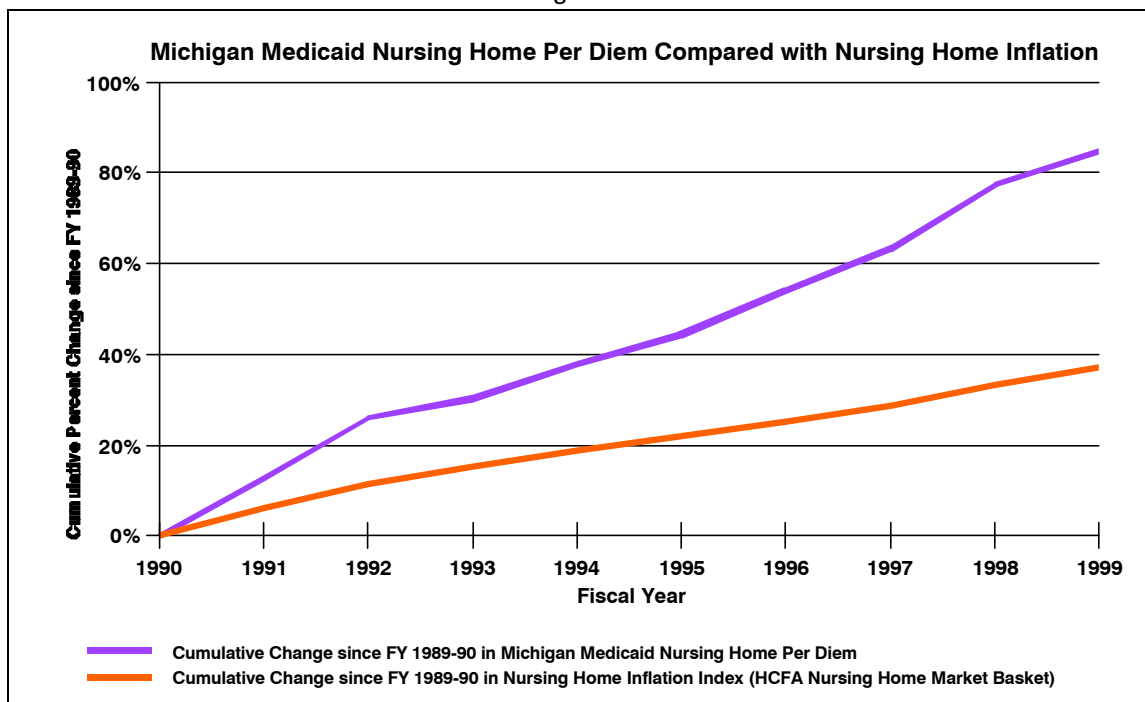
Table 1 displays the per diem expenditures by Medicaid on Class I nursing homes, from fiscal year (FY) 1989-90 through FY 1998-99.

Table 1

MICHIGAN MEDICAID PER DIEM, CLASS I NURSING HOMES				
<u>Fiscal Year</u>	<u>Average Medicaid Nursing Home Per Diem</u>	<u>Year-to-Year Increase</u>	<u>Cumulative Increase</u>	<u>HCFA Nursing Home Market Basket</u>
1989-90	\$51.58	-----	-----	-----
1990-91	58.21	12.9%	12.9%	6.0%
1991-92	64.88	11.5	25.8	11.3
1992-93	67.12	3.5	30.1	15.2
1993-94	71.01	5.8	37.7	18.7
1994-95	74.25	4.6	44.0	22.1
1995-96	79.46	7.0	54.1	25.1
1996-97	84.17	5.9	63.2	28.7
1997-98	91.49	8.7	77.4	33.4
1998-99	95.28	4.1	84.7	37.2

Source: Michigan Department of Community Health

Figure 1



As Table 1 and Figure 1 indicate, the average per diem rate paid to Michigan Class I nursing homes has increased by almost 85% over nine years, or an average of 7.1% per year. This

compares with an increase in the Health Care Finance Administration (HCFA) market basket of nursing home costs of 37.2% (3.6% per year) over the same period. One may conclude that Michigan Medicaid nursing home reimbursements have increased almost twice as fast as nursing home cost inflation¹.

There is little change in this picture if the MCFs and LTCUs are included. It is true that these facilities' per diem rates have increased at a slower rate (65% over the nine years), but even if they are included in the mix, the overall increase is still 81.0% over nine years, or 6.8% per year.

Table 1 shows that there were large increases in the per diem rate in FY 1990-91 and FY 1991-92 and that subsequent increases were smaller. Among the key factors in the increases in the first two years were changes in nursing home standards mandated by the Federal Omnibus Budget Reconciliation Act (OBRA). Even if those first two years are excluded, however, the average per diem increased by 5.6% per year for Class I nursing homes (as well as all facilities), during a period in which the nursing home cost inflation index went up 3.0% per year. Even over this seven-year period, Medicaid nursing home revenues increased 20% faster than did the index that appears to reflect most accurately nursing home cost inflation.

One may ask why the nursing home per diem rates increased so much. The answer is found in the way the rates themselves are set and updated each year.

In any given year there are three potential adjustments to nursing home rates. First, the nursing home's base funding is adjusted to reflect audited costs from the most recently completed prior year. While there is a lag, this adjustment ensures that any funding changes from prior years become part of the funding base for the facility.

Second, an overall economic adjustment, usually a flat percentage, is added to the adjusted base. Until the repeal of the Federal Boren Amendment (through and including FY 1997-98), this adjustment was calculated by taking the change in the McGraw-Hill Data Resources Incorporated (DRI) inflation index, adding 1%, and then dividing by two (the result is divided by two since the wage pass-throughs also were implemented in these years and provided additional funding). Since FY 1998-99, the overall economic adjustment has been any explicit economic increase approved by the Legislature.

Third, any wage pass-through funding approved by the Legislature is included in the base. The use of wage pass-throughs began in the late 1980s after the Legislature expressed concern about wage levels in nursing home facilities, particularly for nurses' aides. As the wages paid were barely above the minimum wage, the nursing homes were competing with fast food restaurants and other low-wage employers for their entry level employees. In addition, nursing homes also complained that low wages led to high turnover of such staff. Furthermore, it was noted that wages and benefits make up 70%-80% of the costs for nursing facilities. The State agreed to reimburse the nursing homes (usually for up to 50 cents per hour) for wage increases given to their staff. As these costs then became part of the cost base in subsequent years, the wage pass-through funding is permanent and cumulative over the years.

WAGE PASS-THROUGHS: A CLOSER LOOK

The first wage pass-through was implemented in FY 1989-90. This pass-through was limited to direct care personnel (registered nurses or RNs, licensed practical nurses or LPNs, and nurses' aides), who comprise 70% of all nursing home staff. Other personnel were not covered, nor

were employee hours spent on non-Medicaid functions covered (covering those hours with a wage pass-through would have resulted in a loss of Federal match). Furthermore, various wage-linked increased payroll costs (Social Security and Medicare taxes, unemployment insurance payments, and workers' compensation) were not covered. In FY 1990-91 the program was altered to permit wage pass-through funding if the employer could demonstrate that the employee wages had been increased by more than the nursing home inflation rate as measured by McGraw-Hill's DRI Index.

In both FY 1989-90 and FY 1990-91, the wage pass-through program saw very limited participation. The setup proved to be too cumbersome and costly for nursing homes to bother applying for money to pay for increases. Another factor was the recession of 1990-91, which meant there was little upward labor market pressure on wages.

The current era of nursing home wage pass-throughs began with the FY 1992-93 Medicaid budget. The FY 1992-93 wage pass-through covered all employees in nursing homes rather than just RNs, LPNs, and nurses' aides, but only for Medicaid hours (again, Federally matched Medicaid dollars may not be used for non-Medicaid services). Additionally, as the DCH has noted, "there also was a consideration for the increased employer costs related to granting wage increases," such as Social Security taxes.

Since FY 1992-93, the wage pass-through has been a regular part of the Medicaid budget. Table 2 displays the size of the wage pass-throughs over the years and their effect on the wages of nurses' aides (who are the lowest-paid direct care employees at nursing homes and comprise over 40% of all staff and 65% of direct care staff).

Table 2

HISTORY OF WAGE PASS-THROUGH				
<u>Fiscal Year</u>	<u>Wage Pass-Through Authorized by Legislature</u>	<u>Cumulative Pass-Through (per hour) *</u>	<u>Average Nurses' Aide Wages All Facilities</u>	<u>Percent of Wages Paid by State</u>
1992-93	up to \$0.50/hour	\$0.50		
1993-94	up to \$0.50/hour	1.00		
1994-95	up to \$0.50/hour	1.50		
1995-96	up to \$0.50/hour	2.00	\$7.22	27.7%
1996-97	up to \$0.50/hour	2.50	7.65	32.7
1997-98	up to \$0.50/hour	3.00	8.12	36.9
1998-99	up to \$0.50/hour	3.45	8.60	40.1
1999-2000 **	up to \$0.75/hour	4.12	9.27	44.4
*FY 1998-99 and FY 1999-2000 values are lower due to inclusion of Social Security Medicare, and unemployment payroll costs in the pass-through.				
** Estimated				

Source: Michigan Department of Community Health

As one can see in Table 2, the cumulative wage pass-through now exceeds \$4 per Medicaid-paid hour of work. In fact, the wage pass-through now covers almost 45% of the average nurses' aide wage, with the nursing home paying \$5.15 per hour, or exactly the minimum wage, and the State picking up the rest of the cost.

What one also sees is that the wage pass-through program has had a large impact on the wages paid to nurses' aides. Their average hourly wage has increased by over \$2 per hour (or 28%) over the past four years. While one may argue whether or not this has been a sufficient increase, it is clear that the program has helped lead to wage increases of over 6% per year.

Table 3 displays information on wages for the three primary direct care employee groups at nursing homes: RNs, LPNs, and nurses' aides. The data include the minimum and maximum average hourly wages paid at Michigan facilities with more than a few such employees as well as the overall average for each group.

Table 3

AVERAGE FACILITY HOURLY WAGES BY JOB CATEGORY REGISTERED NURSES, LICENSED PRACTICAL NURSES, AND NURSES' AIDES					
	<u>FY 1995-96</u>	<u>FY 1996-97</u>	<u>FY 1997-98</u>	<u>FY 1998-99</u>	<u>3 Year Change</u>
Min. RN Facility Avg. Wage	\$11.36	\$12.12	\$12.51	\$12.74	
Max. RN Facility Avg. Wage	\$20.69	\$22.88	\$25.76	\$23.84	
Overall RN Average Wage	\$15.80	\$16.06	\$16.72	\$17.27	\$1.47
Percent Change	---	1.6%	4.1%	3.3%	
Min. LPN Facility Avg. Wage	\$8.91	\$8.98	\$9.53	\$10.24	
Max. LPN Facility Avg. Wage	\$16.98	\$17.21	\$17.40	\$19.40	
Overall LPN Average Wage	\$12.90	\$13.28	\$13.71	\$14.30	\$1.40
Percent Change	---	2.9%	3.3%	4.3%	
Min. Aide Facility Avg. Wage	\$4.83	\$5.29	\$5.65	\$5.84	
Max. Aide Facility Avg. Wage	\$10.60	\$11.17	\$11.74	\$11.90	
Overall Aide Average Wage	\$7.22	\$7.65	\$8.12	\$8.60	\$1.38
Percent Change	---	6.0%	6.1%	5.9%	

Source: Michigan Department of Community Health

Table 3 indicates that the increases in wages have almost exactly matched the size of the wage pass-through over the same period. In other words, the facility share of the wage base for Medicaid hours has been frozen over this period, while the State has picked up the entire cost of any wage increases provided to these three classes of employees.

While the wage pass-through has increased wages, it is obvious that the facilities, on average, have not increased wages for Medicaid hours worked beyond the increase dictated by the wage pass-through. Administrators for the facilities would note, quite correctly, that they have to increase all wages, not just the Medicaid wages, and they must pay for the non-Medicaid wage increases out of their non-Medicaid revenue.

On average, given a three-year increase of about \$1.40 per hour and a 67% Medicaid volume, the facilities saw an increase, due to the wage pass-through, in their non-Medicaid costs of

about 4% per year, or about 1.3% on their entire cost base.

Therefore, it is true that, while the Medicaid wage pass-through appears to cover all Medicaid costs, there are cost implications for the nursing homes on their non-Medicaid side of the business. On the other hand, these cost implications are relatively minor and are certainly smaller than the labor market pressures currently pushing up entry-level wages.

FACILITY OCCUPANCY

Unlike hospitals, whose average occupancy is under 60%, Michigan nursing homes have an occupancy rate of over 90%. Table 4 displays occupancy rates from the past four years, by region in Michigan. There has been a slight downward trend in occupancy over the past few years, with an overall decline from 92.3% to 90.3%. This trend has been most pronounced in Metro Detroit and the outstate Lower Peninsula.

Table 4

MICHIGAN NURSING HOME OCCUPANCY AND VOLUME BY PAYER				
	<u>FY 1995-96</u>	<u>FY 1996-97</u>	<u>FY 1997-98</u>	<u>FY 1998-99</u>
Upper Peninsula	96.26%	97.60%	95.84%	96.94%
Northwest Lower Peninsula	94.54	95.00	94.34	91.25
Northeast Lower Peninsula	94.43	94.26	93.79	92.31
Metro Detroit/Ann Arbor	93.50	93.31	91.87	90.74
Southeast Michigan	90.09	89.69	89.92	89.15
Southwest Michigan	93.10	92.27	91.81	89.65
Statewide	92.29	91.97	91.53	90.32
Medicaid Volume	67.73	67.43	67.27	67.57
Medicare Volume	10.64	11.49	11.61	11.34
Other Volume	21.64	21.07	21.13	21.09

Source: Michigan Department of Community Health

While this trend is minor, the decline in occupancy has been seen in most states (and Michigan's occupancy numbers appear to be close to the national average). There are likely a number of reasons for this small decline, including shorter stays, demographic changes, and the increased use of alternative community services.

Of further note is the breakdown of volume. Medicaid has held steady at between 67% and 68% of total volume. On a national level the percentage is 68%. There has been a slight increase in Medicare volume and a commensurate small decrease in private pay/private insurance volume.

The latter two trends also have been seen at the national level. On occupancy and payer issues, Michigan appears to be quite representative of the nation as a whole.

RATE INCREASES FOR LONG TERM CARE VERSUS THOSE FOR OTHER MEDICAID PROVIDERS

A comparison of payment increases for long term care services with increases for other Michigan Medicaid providers is displayed in Table 5. The results, which include explicit per diem increases as well as other adjustments (such as funding pools), are fairly clear. Long term care reimbursements have increased at a faster rate than reimbursements for other major Medicaid providers.

Table 5

INCREASES IN PAYMENTS TO MEDICAID PROVIDERS FROM FY 1996-97 ONWARD						
	FY 1996-97	FY 1997-98	FY 1998-99	FY 1999- 2000	Cumulative (Compounded)	Senate FY 2000-01
Inpatient *	2.7%	2.7%	0.0%	3.1%	8.8%	4.0%
Outpatient *	0.0	0.0	0.0	3.1	3.1	11.0
Physician *	0.0	0.0	5.0	4.0	9.2	11.0
Dentists **	0.0	0.0	0.0	12.5	12.5	4.0
Long Term Care	6.4	8.1	4.0	7.4	28.5	4.0
* FY 1998-99 and FY 1999-2000 increases provided as a payment pool, not as an increase in rates.						
** FY 1999-2000 increases provided as a payment pool and certain rates, not as an across-the-board increase						

Source: Senate Fiscal Agency budget histories and Michigan Department of Community Health

One difference is that the changes in long-term care reimbursement have been, exclusively, increases in the average per diem rate. Changes in reimbursement rates for other providers have included both explicit rate increases as well as funding pools distributed to providers due to Medicaid volume or other considerations. Even with these pools included, however long term care has fared significantly better than other providers.

What is even more interesting is the effect of this 28.5% increase in per diem when one sets aside the wage pass-throughs. Since the increase in the average wage has been nearly identical to the wage pass-through, 100% of the regular economic adjustments have gone to non-wage costs. Since wages are, at minimum, 70% of a facility's costs, this means that about \$130 million in increases have gone to 30% (or \$240 million) of the FY 1995-96 base. This equates to a 53.8% (or 11.4% per year) economic increase for nursing homes' non-wage costs over the last four years.

CONCLUSIONS

Most of this year's discussion about Medicaid has focused on payment rates for physicians and hospitals and questions about managed care, but it must be noted that payment rates for long term care have been, traditionally, a major issue in deliberations on the Medicaid budget.

Unlike the case with other providers, Medicaid is the major payer for long term care services in Michigan, with 67% of occupied beds used by Medicaid clients. This compares with about 14% Medicaid utilization in Michigan hospitals. Because of this, the adequacy (or lack thereof) of Medicaid rates can have a tremendous impact on the nursing home industry.

An examination of the available data indicates that payments to nursing homes, even after the implementation of OBRA, have increased almost twice as fast as the corresponding nursing home inflation index. The main reason for this is that nursing homes may receive up to three potential adjustments to their rates: a base adjustment reflecting audited costs; any explicit economic adjustment; and any wage pass-through funding.

The wage pass-through program was first implemented over a decade ago, and was first widely used in FY 1992-93. After eight years of pass-throughs, the cumulative wage pass-through now exceeds \$4 per hour and covers almost 45% of the average nurses' aide wage. The end result has been increased average wages for nursing home employees, but these wage increases have tracked, almost cent for cent, with the size of the wage pass-throughs. Because these funds have basically covered the bulk of wage increases for nursing home staff, it is less than clear as to what the non-wage pass-through economic adjustments have been used for. If one assumes that salaries and wages account for 70% of a nursing home's costs and that a nursing home received a 4% economic increase on top of the wage pass-through (as was the case in the current fiscal year), then the effective increase for non-wage costs would amount to 13.3%. This may be one of the reasons that the cumulative economic increases granted by the State for Medicaid nursing home care have far exceeded the increase one would have expected based on the HCFA Nursing Home Market Basket.

Medicaid nursing home occupancy has declined slightly over the last four years, but remains high, at just over 90%. There have been only slight shifts in the percentage of clients covered by various payers and, in both cases, trends in Michigan have been very similar to national trends.

In the final analysis, there is no question that Michigan nursing homes servicing Medicaid recipients have historically and consistently received economic increases unmatched by increases for any other Medicaid providers. The estimated four-year increase for the non-wage portion of the nursing home base is over 50%. It may be that there are very valid public policy reasons for these increases, but that question is beyond the scope or purview of this paper. The SFA would only note that these increases have also outstripped the level of increases expected from any known nursing home specific cost index.

ENDNOTE

1. Two other indices, the Nursing Home Care (Public Payers) component of the PPI and the same component from the All Health Care Index of the CPI, were reviewed. These components have benchmark dates of December, 1994 and 1996 respectively, and show annual growth rates of 4.75% and 3.95% against nursing home Medicaid inflation updates of 6.4% and 6.2% respectively.